POC #2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/12/13

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445457	A. BUILDING _____ B. WING _____	08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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F 000	INITIAL COMMENTS During the recertification survey and complaint investigation (numbers 31633, 30865, 31635) conducted on August 26-28, 2013, at East Tennessee Health Care, no deficiencies were cited under 42 CFR PART 483.13, Requirements for Long Term Care, related to the complaint investigations.	F 000		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure the discharge	F 202	F202 **483.12 (a) (3) Documentation for Transfer/Discharge of Res** **SS=D** **Requirement:** When the facility transfers or discharges a resident under and of the circumstances specified in paragraph (a) (2) (i) through (v) of this section, the resident's clinical record must be documented. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 202	Continued From page 1 documentation was available for two residents (#18, #86) of twenty discharged residents reviewed. The findings included: Medical record review revealed Resident #18 was admitted to the facility on March 14, 2013, and discharged to home on April 15, 2013. Medical record review revealed Resident #86 was admitted to the facility on April 12, 2013, and discharged on April 30, 2013. Continued review of the medical records revealed no documentation of a discharge summary for residents #18 and #86. Interview with Licensed Practical Nurse #2 on August 26, 2013, at 3:26 p.m., in the hallway, confirmed there was no discharge summary documented for residents #18 and #86.	F 202	documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. 1. Staffing Coordinator completed DC summary for residents #18 and #86 on 9/10/13. 2. 100 % audit of all DC charts from 1/1/13 through present completed 9/11/13 by Staffing Coordinator. 3. ADON In-serviced Staffing Coordinator on 8/26/13 that DC summary to be completed within 48 hours of resident discharge. 4. DON or nursing management to review DC summary audit in daily QA M-F for 30 days then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met the	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	2		

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272	**F 272** **483.20 (b) (1) Comprehensive Assessments** **SS=D** **Requirement:** The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	

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F 272	Continued From page 2 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess significant weight loss for one resident (#55), and failed to accurately assess the bilateral lower extremity contractures for one resident (#75) of thirty-one residents reviewed. The findings included: Resident #55 was admitted to the facility on April 4, 2013, with diagnoses including Coronary Artery Disease, Peripheral Arterial Disease, History	F 272	1. Resident #55 MDS assessment for 5/2/13 was modified on 9/11/13 to reflect accurate weight by THM MDS Consultant. Resident #75 MDS assessment for 5/24/13 was modified on 8/27/13 to reflect bilateral lower extremity functional limitation by MDS Coordinator. 2. 100 % audit of current MDS assessment of all residents was completed by 9/16/13 by THM MDS Consultant. 3. THM MDS Consultant in-serviced/educate MDS Coordinator/Backup MDS Coordinator and all members of Interdisciplinary Team (IDT) regarding accuracy and importance to review documentation prior to completion of MDS Assessment on 9/12/2013. 4. Nurse Management or THM MDS Consultant will complete audit of all	

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F 272	Continued From page 3 Deep Vein Thrombosis, Aortic Stenosis, and Oropharyngeal Dysphagia. Review of the Admission Minimum Data Set (MDS) dated April 11, 2013, revealed the resident weighed 127 pounds with no weight loss or gain. Medical record review of the Patient Weight Record revealed the following weight in pounds: 1.) April 4, 2013, Admit 127.2; 2.) April 15, 2013, 121, a loss of 6 pounds or 4.7 percent (%); and 3.) April 22, 2013, 120, a loss of 7 pounds since admission or 5.5%, a significant weight loss. Review of a Registered Dietitian's (RD) note dated April 24, 2013, revealed "...Resident referred to RD r/t (related to) significant weight loss since admission. Admission weight 127.2# (pounds), current weight 120#..." Review of the 30 day Prospective Payment System (PPS) assessment dated May 2, 2013, revealed the resident weighed 120 pounds with no weight loss or gain. Interview on August 28, 2013, at 11:00 a.m., with the MDS coordinator and the Dietary Manager, in the MDS office, confirmed the facility failed to accurately assess the significant weight loss on the thirty day PPS. Resident #75 was admitted on January 7, 2012, and readmitted on July 7, 2012, with diagnoses including Hypertension, Cirrhosis, Aphasia, Head Trauma, Right Hemiparesis, Neurogenic Bladder, and Decubitus Ulcer. Medical record review of a Quarterly Minimum	F 272	completed assessments daily M-F in Morning QA for 30 days then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met the Administrator/Nurse Management will re-in-service and continue monitoring until substantial compliance is achieved. Completed By: 09/20/2013	

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F 272	Continued From page 4 Data Set (MDS) dated May 24, 2013, revealed the resident required extensive assistance with all Activities of Daily Living (ADL's), and had functional limitation in range of motion on one side in the lower extremity. Observation on August 26, 2013, in the resident's room, revealed the resident lying in the bed with bilateral contractures of the lower extremities. Interview with the Director of Nursing (DON) on August 26, 2013, at 2:50 p.m., at the Nurse's Station revealed the resident has bilateral contractures in the lower extremities. Continued interview confirmed the facility failed to accurately assess the resident's contractures.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	**F 279 483.20 (d), 483.20 (k) (1) Develop Comprehensive Plan of Care** **SS=D** **Requirement:** A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. A facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a	

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F 279	Continued From page 5 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to develop a care plan to address incontinence for one resident (#23) of thirty-one residents reviewed. The findings included: Resident #23 was admitted to the facility on January 18, 2012, with diagnoses including Cerebral Vascular Accident, Diabetes, Hypertension, and Depression. Medical record review of a Minimum Data Set (MDS) dated May 9, 2013, revealed " ...resident occasionally incontinent of urine and always continent of bowel. Continued medical record review of a MDS dated May 23, 2013, revealed " ...resident usually incontinent of bladder and always incontinent of bowel..." Interview and record review of the resident care plan last updated July 10, 2013, with the Assistant Director of Nursing on August 28, 2013, at 11:46 a.m., in the facility conference room confirmed the care plan failed to reflect the resident's incontinence.	F 279	resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. 1. Resident # 23 Care Plan was updated on 8/28/2013 to reflect current incontinent status by MDS Coordinator. 2. 100 % audit of all current resident care plans will be completed by 9/20/13 by THM MDS Consultant. 3. Administrator/DON in-serviced MDS and licensed nurses regarding accurate completion of assessments and care plan on 9/16/2013. If any nurse missed the in-service, he or she will be in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. Nurse Management or THM MDS Consultant will complete audit of all completed/revised care plans daily M-F in Morning QA for 30 days and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met the	Completed By: 09/20/2013
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or			

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F 280	Continued From page 6 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan to address the use of hand splints and/or washcloths for one resident (#29) of thirty-one residents reviewed. The findings included: Resident #29 was admitted to the facility on February 22, 2012, with readmission on June 21, 2013, with diagnoses including Diabetes Mellitus, Bi-Polar Disorder, Schizophrenia, Chronic Atrial Fibrillation, Aspiration Pneumonia, Morbid Obesity, and Coronary Artery Disease. Medical record review of the Nurse's Admission/Readmission Assessment dated June 21, 2013, revealed "...Contractures: Hand (Right)..."	F280	Administrator/Nurse Management will re-in-service and continue monitoring until substantial compliance is achieved. **F280** **483.20 (d) (3), 483.10 (k) (2) Right to Participate, Planning Care – Revise CP** **SS=D** **Requirement:** The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the residents' legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.	Completed By: 09/20/2013

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F 280	Continued From page 7 Medical record review of the June and July 2013, Recapitulation Orders revealed "Keep padding with placing 1 washcloth to both palms to keep nails from digging in palms. Monitor daily." Medical record review of the Admission Care Plan dated June 21, 2013, revealed "...Problem: Contractures-hands-roll to palms..." Medical record review of the current care plan dated July 10, 2013, revealed the facility failed to address the hand contracture and the washcloths and/or splints application. Review of the undated Nurse Aide Communication Worksheet revealed "...Contractures hands..." Further review revealed the hand splints and/or washcloths application were not addressed. Review of the nurse aide care sheet, updated on July 29, 2013, revealed the splints and/or washcloths application were not addressed. Medical record review of the telephone order dated August 21, 2013, revealed "Keep padding with washcloth or inflatable short hand orthoses to both hands to keep nails from digging into palms. Monitor daily." Observation on August 26, 2013, during the lunch meal in the dining room, revealed the resident in a geri-chair, prior to and during the resident being fed, with no hand splints or washcloths in the hands. Further observation through out the day, of the resident in the resident's room, while in bed or in the geri-chair, revealed the resident did not have hand splints and/or washcloths applied.	F 280	1. Resident # 29's care plan updated 8/27/2013 to include hand splints/washcloths by MDS Coordinator. 2. 100% audit of all care plans was completed by 9/20/2013 by THM MDS Consultant. 3. Administrator/DON and ADON in-serviced MDS and licensed nurses regarding accurate completion/revision of care plans on 8/30/2013 and 9/16/2013. If any nurse missed the in-service, he or she will be in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. Nurse Management or THM MDS Consultant will complete audit of all completed/revised care plans daily M-F in Morning QA for 30 days and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met the Administrator/Nurse Management will re-in-service and continue monitoring until substantial compliance is achieved.	Completed By: 09/20/2013

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F 280	Continued From page 8 Observation on August 27, 2013, at 9:00 a.m., of the resident, in the resident's room, in a geri-chair, revealed no hand splints and/or washcloths in the hands. Interview on August 27, 2013, at 3:20 p.m., with the Minimum Data Set Coordinator (MDS), in the MDS office, confirmed the current care plan dated July 10, 2013, did not address the contracture or the application of the hand splints and/or washcloths. Interview on August 27, 2013, at 4:00 p.m., with the Administrator and the MDS Coordinator, in the dining room, confirmed the nurse aide care sheet updated July 29, 2013, and the Nurse Aide Communication Worksheet failed to address the washcloth/splint application.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to apply hand splints and/or washcloths as ordered by the physician for one resident (#29) of thirty-one residents reviewed. The findings included: Resident #29 was admitted to the facility on February 22, 2012, with readmission on June 21,	F 281	**F281 483.20 (k)(3)(i) Services Provided Meet Professional Standards** **SS=D** **Requirement:** The services provided or arranged by the facility must meet professional standards of quality. 1. Resident #29 hand splints were applied on 8/27/13 by Restorative Aide.	

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F 281	Continued From page 9 2013, with diagnoses including Diabetes Mellitus, Bi-Polar Disorder, Schizophrenia, Chronic Atrial Fibrillation, Aspiration Pneumonia, Morbid Obesity, and Coronary Artery Disease. Medical record review of the Nurse's Admission/Readmission Assessment dated June 21, 2013, revealed "...Contractures: Hand (Right)..." Medical record review of the June and July 2013, Recapitulation Orders revealed "Keep padding with placing 1 washcloth to both palms to keep nails from digging in palms. Monitor daily." Medial record review of the telephone order dated August 21, 2103, revealed "Keep padding with washcloth or inflatable short hand orthoses to both hands to keep nails from digging into palms. Monitor daily." Medical record review of the July and August 2013, Treatment Administration Record (TAR) revealed "Keep padding with washcloth or inflatable short hand orthoses to both hands to keep nails from digging into palms. Monitor daily." Further review revealed there was an arrow drawn through the entire month from the first to the end of the month with a notation of "FYI" (For Your Information). Observation on August 26, 2013, during the lunch meal in the dining room, revealed the resident in a geri-chair, prior to and during the resident being fed, with no hand splints or washcloths in the hands. Further observation through out the day, of the resident in the resident's room, while in bed or in the geri-chair, revealed the resident did not have hand splints and/or washcloths applied.	F 281	2. All residents with functional limitations were audited by the Therapy Staff for need for splints and to ensure proper placement on 8/27/2013 – 9/10/2013. 3. Administrator in-serviced all licensed nurses, Restorative Aides, CNAs, Restorative Nurse and or therapy personnel on 9/19/2013 and 9/20/2013 that: Therapy Staff will apply, assess, and monitor splints as ordered until turned over to restorative for maintenance. At this time, the Restorative Aides will monitor and document daily until restorative services are discontinued. Restorative nurse will chart and monitor weekly to maintain compliance. Once discontinued from Restorative services, Charge Nurse/and or Treatment Nurse will monitor placement of splints daily. If any nursing staff missed the in-service, he or she will be	

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F 281	Continued From page 10 Observation on August 27, 2013, at 9:00 a.m., of the resident, in the resident's room, in a geri-chair, revealed no hand splints and/or washcloths in the hands. Interview with Licensed Practical Nurse (LPN) #4 on August 26, 2013, at 4:24 p.m., in the resident's room, with the resident present, confirmed the resident did not have hand splints or washcloths applied. Interview with Certified Nurse Aide (CNA) #2 on August 24, 2013, at 4:24 p.m.,on the 200 hall, confirmed the resident did not have hand splints or washcloths applied since the CNA came on duty at 3:00 p.m. Interview with LPN #5 on August 27, 2013, at 9:00 a.m., in the resident's room, with the resident present, confirmed the resident did not have hand splints or washcloths applied. Further interview revealed the Treatment Administration Record (TAR) contained the documentation for the monitoring of the application of the hand splints and/or washcloths. Interview on August 27, 2013, at 1:45 p.m., with CNA #3, on the 200 hall, confirmed the CNA was on duty on August 26, 2013, and was assigned to the resident. Further interview confirmed the hand splints and/or washcloths were not applied on August 26, 2013, during the 7:00 a.m. to 3:00 p.m. shift. Interview on August 27, 2013, at 4:00 p.m., with the Administrator and the Minimum Data Set (MDS) Coordinator, in the dining room, confirmed the facility failed to apply/monitor the hand splints	F 281	in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. Nurse management to audit daily for 30 days M-F in Morning QA and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met the Administrator/Nurse Management will re-in-service and continue monitoring until substantial compliance is achieved.	Completed By: 09/20/2013

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	445457	A. BUILDING _____ B. WING _____	08/28/2013

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F 281	Continued From page 11 and/or washcloth padding as ordered by the physician.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of a medical dictionary, observation, and interview the facility failed to provide prompt treatment for a pressure ulcer for one resident (#75) of thirty-one residents reviewed. The facility's failure resulted in harm for resident #75. The findings included: Review of facility policy Skin Care Guidelines dated December 2012, revealed "...orders for wound care will be obtained and initiated at the time a wound is identified...Pressure ulcers must be assessed and measured at least once a week...A pressure ulcer is a localized injury to the skin and/or underlying tissueusually over a boney prominence, as a result of pressure, or pressure in combination with shear and/or friction..."	F 314	**F314 483.25 (c) Treatment/Services to Prevent/Heal Pressure Sores** **SS=G** **Requirement:** Based on the comprehensive assessment of resident, the facility must ensure that a resident who enters the facility without pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. Resident #55 was placed on sand bed 8/17/12, and sand bed will continue as long as clinically necessary 2. An audit was performed on 9/19/2013 on all residents to ensure all residents properly treated for any existing skin conditions by Wound	

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F 314	Continued From page 12 Resident # 75 was admitted to the facility on January 7, 2012, and readmitted on December 11, 2012, with diagnoses including Hypertension, Cirrhosis, Aphasia, Head Trauma, Right Hemiparesis, Neurogenic Bladder, and Decubitus Ulcer. Medical record review of a hospital Discharge Summary dated May 26, 2012, revealed "...Admit Date May 2, 2012, Hospital Course: decubitus ulcer on the coccygeal area had grown out proteus mirabilis and MRSA (Methicillin Resistant Staphylococcus Aureus)...patient underwent muscle flap surgery for the decubitus ulcer...aggressive wound care was done...hospital course for wound care was remarkable...wounds slowly healed up...Plan: will need ongoing wound care at the nursing home..." Medical record review of the Treatment Record Dated May 2012, revealed "...May 28, 2012,...ST (stage) II ulcer R buttock..." Medical record review of a Weekly Wound Progress Note dated May 28, 2012, revealed "...Location: R buttock/sacrum ...Date of Onset: 5-28-12...Stage II appears as Stage II...Size: L (length) 4.5 cm (centimeter) W (width) 4.0 cm D (depth) 0.2 cm...Periwound: intact surgical scars visible...no odor...resembles shear/friction..." Medical record review of a Braden Scale for Predicting Pressure Sore Risk dated June 7, 2012, revealed Total Score 14 moderate risk..." Medical record review of a Social Services Notes dated June 11, 2012, revealed "...application request for a sand bed to (insurance) today...awaiting response..." (a "sand bed" is a	F 314	Treatment Registered Nurse and Wound Certified Treatment LPN. Each resident will be assessed upon admission by 2 nurses, daily by CNA, weekly skin assessments by 11-7 nurses for any change in skin condition. 3. The Administrator was in-serviced by the Regional Director of Operations on 9/20/2013 that any specialty item ordered by a physician will be processed immediately with verification of expected delivery with Physician to provide alternate if item unavailable in a timely manner. All Physicians notified via letter on 9/20/2013 that physician will need to provide an alternate if item unavailable in a timely manner by the Administrator. The licensed nursing staff and CNAs were in-serviced by Administrator, DON, and ADON on 9/16/13 on preventative skin care, nutrition and hydration.	

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F 314	Continued From page 13 fluidized air bed. Review of Mosby's Medical Dictionary, 8th Edition, 2009, revealed a fluidized air bed: "minimizes pressure and distributes weight evenly over the support surface. A gentle flow of temperature contrilled air is projected upward through numerous yiny openings called ceramic microspheres.") Medical record review of a Weekly Wound Progress Note dated June 12, 2012, (two weeks since last documented assessment) revealed "...Location: R buttock/sacrum...Date of Onset: 5-28-12...Stage II appears as Stage II...Size: L (length) 12 cm (centimeter) W (width) 5.5 cm D (depth) UTD (unable to determine)...Periwound: denuded...Odor: yes...Exudate: moderate...Other descriptions: Wound bed is 100 % slough..." Medical record review of a Physician's Progress Note dated June 13, 2012, revealed "...S/P (status post) hospitalization for surgical repair of coccyx stage IV pressure wound...heels intact coccyx wound with open areas...looks like wound bed is breaking down...not on specialty mattress (sand bed)...specialty mattress ASAP (as soon as possible)..." Medical record review of a Social Services Notes dated June 13, 2012, revealed "...the precert application (for the sand bed) was missing a CPT (Current Procedure Terminology) code...faxed back..." Medical record review of a Weekly Wound Progress Note dated June 19, 2012, revealed "...Location: R buttock/sacrum...Stage UNST (unstageable)...Tissue Depth Full Thickness...undermining /tunneling: unknown..."	F 314	DON/ADON in-serviced wound nurses regarding support surfaces to promote healing was completed by 9/18/13 and 9/19/13. If any nursing staff missed the in-service, he or she will be in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. Administrator, ADON, and Wound Treatment Team conference call with QSource Representatives Julie Clark and Beth Hercher to discuss Pressure Ulcer Improvement on 9/19/2013. As participant in the CMS QAPI Program, the facility will implement a Pressure Ulcer Performance Improvement as focus for our QAPI initiative. Nurse Management will review new wound care orders, and will review with wound care nurse and doctor as needed for change of support surfaces/treatment as needed daily in morning QA for 30	Completed By: 09/20/2013

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F 314	Continued From page 14 Medical record review of a Social Services Note dated June 20, 2012, revealed "...(insurance) requested clinical info (information) on this patient (in relation to the June 11, 2013 order for the sand bed)...info r/t (related to) pressure ulcers faxed..." Medical record review of a Weekly Wound Progress Note dated June 25, 2012, revealed "...Location: R buttock/sacrum...Tissue Type: Necrotic/Eschar (dead tissue) Odor: yes...6-25-12 wound c/s (culture and sensitivity) collected..." Medical record review of a Social Services Note dated June 25, 2012, revealed "...called (insurance) today to f/u (follow up) on status regarding sand bed..." Medical record review of a Social Services Note dated June 29, 2012, revealed "...spoke with (insurance) today to f/u on progress with sand bed...SSD (Social Service Director) clarified that this patients doctor was wanting him/her to have a sand bed..." Medical record review of a Physician's Progress Note dated June 30, 2012, revealed "...wound still draining...wound c/s grew out MRSA..." Medical record review of a Weekly Wound Progress Note dated July 2, 2012, revealed "...Location: R buttock/sacrum...Date of Onset: 5-28-12...Stage unst appears as unst...Periwound: excoriation shearing from tape...Exudate: copious...Other descriptions: MRSA infection. Surgeon to be called today to have apt (appointment) made...Pain: 0..." Medical record review of a Social Services Note	F 314	days M-F, and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met, Administrator/Nurse management will re-in-service and continue monitoring until substantial compliance is achieved.	Completed By: 09/20/2013

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F 314	Continued From page 15 dated July 2, 2012, revealed "...resident was sent to...(surgeon) r/t wounds..." Medical record review of a Social Services Note dated July 3, 2012, revealed "...called (insurance) explained urgency (to receive sand bed)..." Medical record review of a Social Services Note dated July 9, 2012, revealed "...(insurance) rep (representative) stated bed was approved..." Medical record review of a Weekly Wound Progress Note dated July 11, 2012, revealed "...Location: R buttock/sacrum...Date of Onset: 5-28-12...Stage unst appears as Stage IV...Undermining/Tunneling: 12 clock - 3 clock 0.5 cm...Pain: 0..." Medical record review of a Weekly Wound Progress Note dated July 16, 2012, revealed "...Location: R buttock/sacrum...Dakin's (solution used to treat wound infections) used to treat MRSA...Pain: 0..." Medical record review of a Weekly Wound Progress Note dated July 23, 2012, revealed "...Location: R buttock/sacrum...Decline from last measurement wound more friable (breakable) today...MD notified D/T (due to) increase drainage/odor...Pain Scale: (0-10) 5..." Medical record review of a Social Services Note dated July 24, 2012, revealed "...followed up with (insurance) today...will cont (continue) to push (insurance) for this...product (sand bed)..." Medical record review of a Physician's Progress Note dated July 27, 2013, revealed "...To Whom It May Concern...lack of bed mobility without	F 314		

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F 314	Continued From page 16 assistance...bed bound; had developed decubitus ulcers which required surgery to heal...done very well only with sand bed as evidenced by failed surgery in past (February 2, 2012) when out of sand bed to support..." Medical record review of a Weekly Wound Progress Note dated July 30, 2012, revealed "...Location: R buttock/sacrum...Exudate: large...copious...Odor: yes...Other description: Abt (antibiotic) started again for tx (treatment) of wound. Tip of coccyx bone noted..." Medical record review of a Physician's Progress Note dated July 31, 2012, revealed "...wound worsening...awaiting sand bed insurance company approval...decubitus ulcer with wound infection...Plan: awaiting sand bed, surgical eval (evaluation) pending arrival of bed without sand bed to help will continue to deteriorate..." Medical record review of a Physician's Telephone Order dated July 31, 2012, revealed "...Please have Social Worker check on status of sand bed and let me know..." Medical record review of a Weekly Wound Progress Note dated August 6, 2012, revealed "...Location: R buttock/sacrum...Exudate: copious...Other description: deeper wound bed from coccyx to upper half of wound bed..." Medical record review of a Social Services Notes dated August 7, 2012, revealed "...contacted (Insurance) again...haven't received approved sand bed..." Medical record review of a Weekly Wound Progress Note dated August 8, 2012, revealed	F 314		

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F 314	Continued From page 17 "...Location: R buttock/sacrum...Size: L 10 cm W 10.5 cm D 2 cm...Exudate: copious...Last tx order chg (change) 6/30/12..." Medical record review of a Weekly Wound Progress Note dated August 8, 2012, revealed "...Location: R Ischium...Pressure Ulcer: Stage II appears as Stage II...Date of Onset: 8/8/12...Periwound: H20 (water)blister intact...Exudate: fluid filled..." Medical record review of a Weekly Wound Progress Note dated August 8, 2012, revealed "...Location: R Lateral Malleolus (ankle)...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 1.5 W 2 cm D 0.3...Other descriptions/comments: silver surgical appliance noted to wound bed. The top of screw is noted..." Medical record review of a Braden Scale for Predicting Pressure Sore Risk dated August 8, 2012, revealed Total Score 13 moderate risk..." Medical record review of a Social Services Notes dated August 9, 2012, revealed "...Per Administrator's advice this writer called a representative of (sand bed company) to see if they could help us get our patient a sand bed writer explained urgent nature of the situation..." Medical record review of a Weekly Wound Progress Note dated August 13, 2012, revealed "...Location: R buttock/sacrum...Size: L 10 cm W 10.5 cm D 1 cm...Exudate: copious..." Medical record review of a Weekly Wound Progress Note dated August 13, 2012, revealed "...Location: R Ischium...Pressure Ulcer: Stage II appears as Stage I...Date of Onset:	F 314		

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F 314	Continued From page 18 8/8/12...Periwound: H20 (water) blister intact...Exudate: fluid filled..." Medical record review of a Weekly Wound Progress Note dated August 13, 2012, revealed "...Location: R Lateral Malleolus...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 2 W 1.5 cm D 0.2..." Medical record review of a Social Services Notes dated August 14, 2012, revealed "...left VM (voice mail)...to check on progress (of sand bed)..." Medical record review of a Social Services Notes dated August 17, 2012, revealed "...sand bed finally arrived today...patient smiled when first laid on it seemed to breathe easier..." Medical record review of a Physician's Telephone Order dated August 17, 2013, revealed "...D/C (discontinue) order for surgeon r/t (related to) decubitus ulcer try trial with sand bed..." Medical record review of a Physician's Progress Note dated August 19, 2012, revealed "...doing better sand bed received has been on it several days wound in gluteal area healing...healing decubitus ulcer..." Medical record review of a Weekly Wound Progress Note dated August 20, 2012, revealed "...Location: R buttock/sacrum...Size: L 10 cm W 10 cm D 1 cm...Exudate: copious...Other description/comments: area around coccyx bone is deeper...Other: (sand bed) 8-17-12..." Medical record review of a Weekly Wound Progress Note dated August 20, 2012, revealed "...Location: R Ischium ...Resolved...(sand bed	F 314		

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F 314	Continued From page 19 manufacturer's name) bed August 17, 2012..." Medical record review of a Weekly Wound Progress Note dated August 21, 2012, revealed "...Location: R Lateral Malleolus...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 1.8 W 0.8 cm D 0.2...Other descriptions/comments: silver appliance is still visible..." Medical record review of a Weekly Wound Progress Note dated August 27, 2012, revealed "...Location: R buttock/sacrum...Size: L 9 cm W 9 cm D 0.8 cm...Odor: none...Undermining/Tunneling: none..." Medical record review of a Weekly Wound Progress Note dated August 27, 2012, revealed "...Location: R Lateral Malleolus...Date of Onset: 8/8/12...Pressure Ulcer: Stage IV appears as a Stage IV...Size: L 1.5 W 0.8 cm D 0.2..." Medical record review of a Weekly Wound Progress Note dated September 3, 2012, revealed "...Location: R buttock/sacrum...Size: L 7 cm W 8.5 cm D 0.5cm...Odor: none...Undermining/Tunneling: none..." Medical record review of a Weekly Wound Progress Note dated September 10, 2012, revealed "...Location: R buttock/sacrum...Size: L 6.5 cm W 8 cm D 0.3 cm...Odor: none...Undermining/Tunneling: none..." Medical record review of a Weekly Wound Progress Note dated September 17, 2012, revealed "...Location: R buttock/sacrum...Size: L 6 cm W 7 cm D 0.2 cm...Odor: none...Undermining/Tunneling: none..."	F 314		

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F 314	Continued From page 20 Medical record review of a Weekly Wound Progress Note dated September 24, 2012, revealed "...Location: R buttock/sacrum...Size: L 5.8 cm W 6.8 cm D 0.2 cm...Odor: none...Undermining/Tunneling: none..." Medical record review revealed the resident had been discharged to the hospital on September 30, 2012, readmitted on October 8, 2012, discharged to the hospital on November 27, 2012, and readmitted December 11, 2012. Continued medical record review revealed the resident had surgical correction of decubitus ulcers. Observation on August 27, 2013, at 1:30 p.m., in the resident's room, revealed the resident on a sand bed and the wound care nurse provided wound care/dressing change. The decubitus on the right buttocks had two areas measuring 1) 1.5 cm x 0.8cm; 2) 0.06 x 0.5cm with no depth, odor, and/or drainage noted. Interview with the Social Service Director (SSD) on August 28, 2013, at 9:00 a.m., in the SSD office, revealed the SSD stated attempted to obtain insurance approval for payment and delivery of the sand bed for resident #75, June 11 to August 17, 2012. Further interview revealed "The facility considered paying for the (sand) bed at the end due to the resident had not been getting any better." Interview with the Assistant Director of Nursing (ADON) on August 28, 2013, at 9:41 a.m., in the Administrator's Office, revealed the resident's physician had been notified the facility was having problems obtaining the sand bed. Continued	F 314		

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F 314	Continued From page 21 interview revealed the physician stated he wanted the resident to have the sand bed and continue to try 9to obtain the bed). Interview with the Administrator on August 28, 2013, at 9:43 a.m., in the Administrator's Office, revealed the facility did not purchase/rent the sand bed because the facility did not have a contract with any of the companies furnishing sand beds. Continued interview revealed the facility had attempted to get insurance approval for the sand bed from a supplier from June 11, 2012, through August 17, 2012 (67 days). Further interview confirmed the resident's decubitus ulcer on the R buttock/sacrum continued to deteriorate and the resident developed two more pressure ulcers. Interview with the resident's physician by telephone on August 28, 2013, at 11:40 a.m., revealed the resident had been hospitalized for surgery related to the wounds and the surgeon ordered the facility to provide a sand bed for the resident. Continued interview revealed the resident had done well on a sand bed in the hospital. Further interview revealed the physician had been unsure of the time frame but stated "It took a while for the insurance company to approve the bed and the resident's wounds continued to deteriorate."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315	**F315 483.25 (d) No Catheter, Prevent UTI, Restore Bladder** **SS=D**	

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F 315	Continued From page 22 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure that a resident who was only occasionally incontinent of bladder and always continent of bowel was revaluated after a decline in continence for one resident (#23) of thirty-one residents reviewed. The findings included: Resident #23 was admitted to the facility on January 18, 2012, with diagnoses including Cerebral Vascular Accident, Diabetes, Hypertension, and Depression. Medical record review of a Minimum Data Set (MDS) dated May 9, 2013, revealed " ...resident occasionally incontinent of urine..." Continued medical record review of a MDS dated May 23, 2013, revealed " ...resident usually incontinent of bladder..." Interview with the Restorative Nurse, at the nurse's station, on August 28, 2013, at 9:21 a.m., confirmed the resident had not been reevaluated for a possible bladder program.	F 315	**Requirement:** Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1. Resident #23 began a restorative toileting program on 9/3/13. 2. On 9/10/13, ADON audited and updated current census list to reflect all residents who are incontinent of B/B. The THM MDS Consultant Nurse audit completed on 9/19/13 to reflect any incontinent residents. 3. Administrator/DON/ADON in-serviced all licensed	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident			

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	445457	A. BUILDING _____ B. WING _____	08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TENNESSEE HEALTH CARE	485 ISBILL RD MADISONVILLE, TN 37354

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F 315	Continued From page 22 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure that a resident who was only occasionally incontinent of bladder and always continent of bowel was revaluated after a decline in continence for one resident (#23) of thirty-one residents reviewed. The findings included: Resident #23 was admitted to the facility on January 18, 2012, with diagnoses including Cerebral Vascular Accident, Diabetes, Hypertension, and Depression. Medical record review of a Minimum Data Set (MDS) dated May 9, 2013, revealed " ...resident occasionally incontinent of urine..." Continued medical record review of a MDS dated May 23, 2013, revealed " ...resident usually incontinent of bladder..." Interview with the Restorative Nurse, at the nurse's station, on August 28, 2013, at 9:21 a.m., confirmed the resident had not been reevaluated for a possible bladder program.	F 315	nurses 8/30/2013 and 9/16/2013 that any resident with decline in continent status must have a B&B program initiated. If any nursing staff missed the in-service, he or she will be in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. IDT will review any new admissions, readmissions, and new assessments to capture incontinence for appropriate treatment and prevention of urinary tract infections and to restore as much normal bladder function as possible in morning QA M-F for 30 days, and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met Administrator/Nurse Management will re-in-service/educate until compliance achieved.	Completed By: 09/20/2013
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident			

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F 323	Continued From page 23 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to follow interventions for transferring a resident to prevent accidents for one resident (#6) of three residents reviewed for accidents of thirty-one residents reviewed. The findings included: Resident #6 was admitted to the facility on September 9, 2011, with diagnoses including, Cerebal Vascular Accident with Left Hemiplegia, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, Psychotic Episodes, Depression and Dementia. Medical record review of the quarterly Minimum Data Set dated May 10, 2013, revealed the resident required extensive assistance of one person with bed mobility and transfers. Medical record review of the Care Plan dated March 10, 2013, revealed, "...Sit-to-Stand with transfers..." and the Care Plan updated August 13, 2013, revealed, "...Transfer with assistance of 1-2, use sit to stand lift..." Medical record review of a Nurse Event Note dated August 14, 2013, revealed "...New	F 323	**F323 483.25 (b) Free of Accident Hazards/Supervision/Devices** **SS=D** **Requirement:** The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. 1. DON in-serviced CNA on 8/14/13 that resident should be transferred with a sit to stand and to review nurse aide communication sheets to obtain information on how to care for individual residents. 2. Audit of all current CNA's with review and completion of Orientation Checklist with focus on review of patient care plan on 9/19/2013 and 9/20/2013 by Nurse Management.	

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F 323	Continued From page 24 employee was attempting to transfer resident from w/c (wheelchair) to bed. Resident moved...leg and became unbalanced and was lowered to floor without injury..." Interview with the Director of Nursing (DON) on August 27, 2013, at 3:00 p.m., in the DON's office, confirmed the Certified Nursing Assistant failed to use the required sit to stand lift (which had been implemented March 10, 2013) while transferring the resident, and the resident had to be lowered to the floor during the transfer.	F 323	3. Administrator in-serviced Staffing Coordinator/Nurse Management on 9/16/2013 of Structured four day orientation program (can be extended for up to two weeks) for all new employees. The orientation checklist will be completed and placed in employee file, once CNA is deemed competent in all areas covered by orientation checklist.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	4. Nurse management will monitor daily M-F in Morning QA times 30 days and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If compliance is not met Administrator/Nurse management will re-in-service/re-educate until compliance is met.	Completed By: 09/20/2013

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F 425	Continued From page 25 by: Based on medical record review, review of pharmacy medication delivery records, facility policy review, and interview, the facility failed to provide pharmaceutical services for one resident (#97) of thirty-one residents reviewed. The findings included: Resident # 97 was admitted to the facility at 5:00 p.m., on Friday, April 12, 2013, with diagnoses including Diabetes Mellitus, Hypertension, End Stage Renal Disease, Hemodialysis, Bradycardia, and Coronary Artery Bypass Graft. Further review revealed the resident left the facility Against Medical Advice on April 16, 2013, at 0945 (9:45 a.m.). Medical record review of the physician orders dated April 12, 2013, included Phos Lo Gel Cap (phosphate binder) 1,334 mg bid (milligrams twice daily), Catapres TTS-3 (hypertension) q (every) 7 days, Dilacor XR (hypertension) 180 mg bid, and Loniten (hypertension) 2.5 mg HS (bedtime). Medical record review of the physician telephone orders dated April 13, 2013, revealed "...Clarification orders: Phos Lo Gel cap 1334 mg BID start when available; Catapres TTS-3 q 7 days start when available; Dilacor XR BID 180 mg start when available..." Medical record review of the April 2013 Medication Administration Record (MAR) revealed the following: 1.) Phos Lo Gel Cap bid: April 12 at 2100 (9:00 p.m.) and April 13 at 0900 (9:00 a.m.) were circled;	F 425	**F425 483.60(a),(b) Pharmaceutical SVC-Accurate Procedures, RPH** **SS=D** **Requirement:** The facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. 1. Resident # 97 was discharged home Against Medical Advice on 4/16/2013. 2. Audited all current residents to ensure all medications available at facility for dispensing on 8/28/2013 by Charge Nurses. On 9/6/13 our main pharmacy, Ampharm secured another back-up pharmacy which is open 24 hours 7 days a week, which also maintains a greater selection of medications.	

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F 425	Continued From page 26 2.) Catapres for 7 days: April 13 was circled and there was no further documentation regarding the administration of the medication; 3.) Dilacor bid: April 12 at 2100, April 13, 15, and 16 at 0900, were circled; there was no documentation for April 14 regarding the medication administration; and no documentation of any other 2100 medication administrations; and 4.) Loniten at HS: April 12, 13, 14, and 15 were circled. Medical record review of the back of the MAR revealed no documentation. Review of the back-up pharmacy delivery record dated April 12 and 13, 2013, revealed the Phos Lo Gel Cap (equivalent) was delivered to the facility on April 13, 2013. Further review revealed no delivery of Catapres, Loniten or Dilacor. Review of the main pharmacy delivery record revealed medications were delivered to the facility on April 16, 2013, at 5:22 p.m., after the resident had left the facility. Review of the facility policy entitled "Admissions", dated July 2013, revealed "...2.) Nurses are responsible for checking off Physician Orders...and seeing that orders are followed. This includes transcribing orders onto MAR and notifying Pharmacy...." Review of the facility policy entitled "Documentation Of Med (Medication) Pass" revealed "...Omissions due to refusal, hospitalization,leaves, etc. must be noted on the MAR with explanation on the back..."	F 425	3. Nursing management in-serviced licensed nursing staff on 9/6/13 and 9/16/13 on procedures/protocol for when medication is not available. Licensed nurses in-serviced on new addition of a pharmacy for back up on 9/6/13, 9/16/13, and 9/19/13 by DON and ADON. If any nursing staff missed the in-service, he or she will be in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. Nurse Management will check all new admission orders to ensure medications are available daily M-F for 30 days and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. If not met, Administrator and Nurse Management will re-in-service/re-educate until substantial compliance is achieved.	Completed By: 09/20/2013

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F 425	Continued From page 27 Interview on August 28, 2013, at 8:20 a.m., with the Assistant Director of Nursing (ADON), in the ADON's office, confirmed the Medication Administration Record (MAR) with circled medication meant the medication had not been administered. Further interview confirmed the facility failed to follow their policy to document the reason for the failure to administer the medication. Interview on August 28, 2013, at 8:40 a.m., by phone with the back-up pharmacy pharmacist, revealed the facility sent the physician orders to the pharmacy on April 12, 2013. Further interview revealed the facility had crossed out the Phos Lo Gel Cap and the Catapres was not completely written and was crossed out on the document provided to the pharmacy. Further interview confirmed the Loniten and Dilacor were not in stock and not provided to the facility. Further interview revealed the facility sent another pharmacy request on April 13, 2013, for Phos Lo Gel Cap, Catapres and Dilacor. Further interview confirmed the pharmacy did not have Catapres or Dilacor in stock and did provide the facility with the Phos Lo Gel Caps on April 13, 2013. Further interview revealed the pharmacy could not break a box of thirty count of Catapres. Interview on August 29, 2013, at 10:09 a.m. in the private dining room, with the ADON, confirmed the back-up pharmacy and the main pharmacy failed to provide the medication as prescribed by the physician from admission, on April 12, 2013, through the discharge, on April 16, 2013, for Phos Lo Gel Caps, Loniten, Catapres and Dilacor.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 28 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, pharmacy recommendation review, and interview the facility failed to ensure a pharmacy review was acted upon timely for one resident (# 20) of thirty-one residents reviewed. The findings included: Resident #20 was admitted to the facility on June 5, 2006, with diagnoses including Organic Brain Syndrome, Insomnia, Dementia, and Psychosis with Agitation. Medical record review of the Physician Recapitulation order's for July (no signed date), revealed " ...Citalopram (antidepressant medication) ...40 mg (milligrams) ...one tab (tablet) by mouth at bedtime. Review of a pharmacy recommendation print date July 30, 2013, revealed " ...might be appropriate to decrease the Citalopram dose ..." Medical record review of a Physician telephone order dated August 17, 2013, revealed " ...change	F 428	**F428 483.60 (c) Drug Regimen Review, Report Irregular** **SS=D** **Requirement:** The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician and the director of nursing and these reports must be acted upon. 1. Resident # 20 received medication reduction on 8/17/2013. 2. An Audit of all Pharmacy Recommendations was completed on 8/28/2013 by DON. 3. The Director of Pharmacy services in-serviced the pharmacy consultants on 8/29/13 to provide reports to the facility no more than 3 business days from the date of consulting. The Pharmacy Consultant will make every effort to send	

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	TN6201	A. BUILDING: _____ B. WING _____	08/28/2013

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		F428	these reports electronically but will also provide a paper copy via intercompany mail delivery. Administrator in-serviced DON or designee on 9/16/2013 to contact doctors regarding any reports to be acted upon via fax, phone, or personal delivery. If no response in timely manner, the medical director will be notified to intercede to maintain compliance. 4. Nurse Management to monitor monthly 3 months, then quarterly 6 months until substantial compliance is achieved. If compliance not met, Administrator will re-in-service/educate until substantial compliance is achieved.	Completed By: 09/20/2013

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F 428	Continued From page 29 celexa (citalopram) to 10 mg PO (by mouth) ...x (for) 1(one) week and d/c (discontinue)..." Interview and medical record review with the Director of Nursing (DON) on August 28, 2013, at 11:07 a.m., in the DON office, confirmed the pharmacy recommendation was not acted upon until eighteen days later.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F441** **483.65 Infection Control, Prevent Spread, Linens** **SS=E** **Requirement:** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Shower room #2 cleaned immediately 8/26/2013. 2. Both shower rooms audited on 8/26/2013 to ensure staff maintains a sanitary area by Charge Nurses. Licensed nurses to audit shower rooms	

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F 441	Continued From page 30 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a sanitary shower room for one of two showers. The findings included: Observation during the initial tour on August 26, 2013, at 8:45 a.m., revealed in shower room #2, three medium size brown fecal debris areas on the floor. Interview with register nurse (RN) #1 at the time of observation, confirmed the areas of brown debris were to have been cleaned. Interview with the Assistant Director of Nursing on August 27, 2013, at 8:22 a.m., in the conference room, confirmed the Certified Nursing Assistants were to clean up all body fluids at the time of occurance.	F 441	daily during routine rounds to ensure compliance. 3. DON/ADON in-serviced nursing staff on proper procedure for infection control and removal of fecal material when in shower room setting and in-serviced Licensed Nurses for daily auditing on 8/26/2013, 8/30/2013, 9/10/2013 and 9/16/2013. If any nursing staff missed the in-service, he or she will be in-serviced prior to return to work. Any new hires will be in-serviced during orientation. 4. Interdisciplinary Team to make monitoring rounds to ensure compliance daily M-F for 30 days and then weekly for 3 months, then biweekly for 1 month until substantial compliance is achieved. The Infection Control Committee will conduct random rounds to ensure Infection Control Protocol compliance is maintained for six (6) weeks. Findings will be reported in the morning QA meeting. If	

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		F428	compliance not met, Administrator and Nurse Management will re-in-service/re-educate until compliance is achieved.	Completed By: 09/20/2013

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE